AMENDED IN SENATE APRIL 28, 2003

SENATE BILL No. 785

Introduced by Senator Ortiz

February 21, 2003

An act to amend Section ~~14105~~ *14124.91* of the Welfare and Institutions Code, relating to Medi-Cal.

LEGISLATIVE COUNSEL'S DIGEST

SB 785, as amended, Ortiz. Medi-Cal *benificiary: 3rd-party coverage.*

Existing law provides for the Medi-Cal program, administered by the State Department of Health Services, pursuant to which medical benefits are provided to public assistance recipients and other low-income persons.

Existing law ~~authorizes the Director of Health Services, under the Medi-Cal program, to limit the rates of payment for health care services, and requires the director to prescribe policies and adopt regulations with respect to rates for payment for services not rendered under contract with prepaid health plans.~~

~~This bill would make technical, nonsubstantive changes to this provision~~ *requires the department, whenever it is cost-effective, to pay the premium for 3rd-party health coverage for beneficiaries under the Medi-Cal program.*

This bill would require the department, notwithstanding the above requirement, to give beneficiaries the option of enrolling in, or maintaining enrollment in, an employer-sponsored health benefits plan for which they are eligible, at the time they apply for the Medi-Cal program, if the department determines that it would be cost-effective to do so. The bill would provide that for these beneficiaries, the

employer-sponsored health benefits plan would serve as their primary source of health coverage and the Medi-Cal program would serve as secondary coverage. It would also require the department to screen persons applying for the Medi-Cal program to determine whether they are eligible for, or enrolled in, an employer-sponsored health benefits plan that would qualify for this option, and to seek any waivers or federal approval necessary to implement the bill.

Vote: majority. Appropriation: no. Fiscal committee: ~~no~~ *yes*. State-mandated local program: no.

The people of the State of California do enact as follows:

~~SECTION 1. Section 14105 of the Welfare and Institutions~~

SECTION 1. Section 14124.91 of the Welfare and Institutions Code is amended to read:

14124.91. *(a)* The State Department of Health Services ~~shall~~, whenever it is cost-effective, *shall* pay the premium for third-party health coverage for beneficiaries under this chapter. The State Department of Health Services shall, when a beneficiary's third-party health coverage would lapse due to loss of employment or change in health status, lack of sufficient income or financial resources, or any other reason, continue the health coverage by paying the costs of continuation of group coverage pursuant to federal law or converting from a group to an individual plan, whenever it is cost-effective. Notwithstanding any other provision of a contract or of law, the time period for the department to exercise either of these options shall be 60 days from the date of lapse of the policy.

(b) (1) Notwithstanding subdivision (a), the department shall give beneficiaries the option of enrolling, or maintaining enrollment, in an employer-sponsored health benefits plan for which they are eligible, at the time they apply for the Medi-Cal program, if the department determines that it would be cost-effective to do so. For these beneficiaries, the employer-sponsored health benefits plan shall serve as their primary source of health coverage and the Medi-Cal program shall serve as secondary coverage. The department shall screen persons applying for the Medi-Cal program to determine whether they are eligible for, or enrolled in, an employer-sponsored health

benefits plan that would qualify for the option provided under this paragraph.

(2) The department shall seek any waivers or federal approval necessary to implement this subdivision.

~~Code is amended to read:~~

~~14105. (a) (1) The director shall prescribe the policies to be followed in the administration of this chapter, may limit the rates of payment for health care services, and shall adopt any rules and regulations as are necessary for carrying out, but are not inconsistent with, the provisions thereof.~~

~~(2) The policies and regulations shall include rates for payment for services not rendered under a contract pursuant to Chapter 8 (commencing with Section 14200). In order to implement expeditiously the budgeting decisions of the Legislature, the director shall, to the extent permitted by federal law, adopt regulations setting rates that reflect these budgeting decisions within one month after the enactment of the Budget Act and of any other appropriation that changes the level of funding for Medi-Cal services. The proposed regulations shall be submitted to the Department of Finance no later than five days prior to the date of adoption. With the written approval of the Department of Finance, the director shall adopt the regulations as emergency regulations in accordance with the rulemaking provisions of the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340), Part 1, Division 3, Title 2 of the Government Code). For purposes of that act, the adoption of these regulations shall be deemed an emergency and necessary for the immediate preservation of the public peace, health, and safety or general welfare.~~

~~(b) (1) Insofar as practical, consistent with the efficient and economical administration of this part, the department shall afford recipients of public assistance a choice of managed care arrangements under which they shall receive health care benefits and a choice of primary care providers under each managed care arrangement.~~

~~(2) Notwithstanding any other provision of law, Medi-Cal beneficiaries shall be entitled to affirmatively select, or to be assigned by default to, any primary care provider as defined in paragraph (1) of subdivision (b) of Section 14088.~~

~~(3) Notwithstanding any other provision of law, when a Medi-Cal beneficiary is assigned, from any source, to a primary care physician, as defined in Section 14254, and that primary care physician is an employee of a primary care provider, as defined in paragraph (1) of subdivision (b) of Section 14088, the assignment shall constitute an assignment to the primary care provider.~~

~~(c) If, in the judgment of the director, the actions taken by the director under subdivision (c) of Section 14120 will not be sufficient to operate the Medi-Cal program within the limits of appropriated funds, he or she may limit the scope and kinds of health care services, except for minimum coverage as defined in Section 14056, available to persons who are not eligible under Section 14005.1. When and if necessary, that action shall be taken by the director in ways consistent with the requirements of the federal Social Security Act.~~

~~(d) The director shall adopt regulations implementing regulatory changes required to initially implement, and annually update, the Centers for Medicare and Medicaid Services' common procedure coding system as emergency regulations in accordance with Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code. For the purposes of the Administrative Procedure Act, the adoption of the regulations shall be deemed to be an emergency and necessary for the immediate preservation of the public peace, health and safety, or general welfare. These regulations shall become effective immediately upon filing with the Secretary of State.~~

~~(e) Notwithstanding any other provision of law, prospective reimbursement for any services provided to a Medi-Cal beneficiary in a nursing facility that is a distinct part of an acute care hospital shall not exceed the audited costs of the facility providing the services.~~

~~(f) Notwithstanding any other provision of law, reimbursement for anesthesiology, surgical services, and the professional component of radiology procedures except for comprehensive perinatal and obstetrical services shall be reduced by 9.5 percent of the amount of reimbursement provided for any of those services prior to the operative date of this subdivision. The director may exclude emergency surgical services performed in the emergency department of a general acute care hospital. To be excluded, emergency surgical services must be performed by an emergency~~

~~room physician or a physician on the emergency department's on-call list.~~

~~(g) (1) It is the intent of the Legislature in enacting this subdivision to enable the department to obtain Medicare cost reports for the purpose of evaluating its Medi-Cal reimbursement rate methodology for nursing facilities.~~

~~(2) Skilled nursing facilities licensed pursuant to Chapter 2 (commencing with Section 1250) of Division 2 of the Health and Safety Code shall submit copies of all Medicare cost reports to the department on the date that the Medicare cost reports are submitted to the Medicare fiscal intermediary.~~

~~(3) Hospitals providing skilled nursing care licensed pursuant to Chapter 2 (commencing with Section 1250) of Division 2 of the Health and Safety Code shall submit a copy of all Medicare cost reports to the department on the date that the Medicare cost reports are submitted to the Medicare fiscal intermediary.~~

O